CHAPTER 13
SECTION 5

APPEAL OF FACTUAL (NON-MEDICAL NECESSITY) DETERMINATIONS

The contractor shall provide for an appeal system allowing full opportunity for proper appealing parties to appeal adverse factual determinations. Factual determinations are issued in cases involving: coverage issues, provider authorization (status) requests, hospice care, foreign claims, denials based on sections other than 32 CFR 199.4, and both medically necessity and factual determinations. Medical or peer review may be necessary to reach a factual determination; e.g., for advice on whether regulation or policy criteria are met. Waiver of liability is not applicable.

1.0. INITIAL DETERMINATION

An initial factual determination is a written decision that is other than a medical necessity determination under Chapter 13, Section 4. For further information relating to initial determinations, refer to Chapter 13, Section 1, paragraph 2.2.1. The initial denial determination is final and binding unless the initial determination is reversed by the contractor or revised upon appeal.

2.0. TIME LIMIT

A request for reconsideration must be filed by the appealing party within 90 calendar days after the date of the notice of the initial denial determination. The contractor shall complete the review and issue its reconsideration determination to all parties within 60 calendar days after the date of receipt of the reconsideration request.

3.0. NOTICE

The contractor shall issue a written reconsideration determination. Refer to Chapter 13, Section 3, paragraph 6.0. for the required content of the notice to the appealing party of the results of the reconsideration determination.

4.0. RECORD

Refer to Chapter 13, Section 3, paragraph 9.0. for the record of the factual reconsideration determination to be maintained by the contractor.

5.0. EXAMPLES OF FACTUAL DETERMINATIONS

5.1. Determinations Related To Coverage Issues

Denial determinations based on coverage limitations contained in 32 CFR 199, the Policy Manual, and other TRICARE guidance, are considered factual determinations. If it is determined that a service or supply is covered, but is not medically necessary, at an

inappropriate level of care, is custodial care or other reasons relative to reasonableness, necessity or appropriateness, the denial will be a medical necessity determination under Chapter 13, Section 4 (see Example 1, below). The following are examples of denials based on coverage limitations:

EXAMPLE 1: A woman received an abortion, meeting the coverage criteria set forth in Policy Manual, Chapter 3, Section 13.3. However, the services are found not to be medically necessary (i.e., not generally accepted by qualified professionals to be reasonable and adequate for the treatment of her condition). Although the coverage criteria are met, because the services are not medically necessary, benefits must be disallowed and appeal rights offered under Chapter 13, Section 4.

EXAMPLE 2: Payment is denied for surgical evacuation of hematomas following removal of breast implants from a previous noncovered augmentation mammoplasty because the beneficiary's hematomas do not constitute a separate medical condition under 32 CFR 199.4(e)(9). Removal of the hematomas is medically necessary, but the denial is based on a coverage limitation because the complication is not a separate medical condition from the noncovered augmentation mammoplasty. This is an example of a case where medical review may be required to determine whether regulation or policy criteria are met.

5.2. Termination Of A Provider

Contractor requirements for terminating a provider's status as a TRICARE-authorized provider are found in Chapter 14, Section 6, paragraph 4.3. Under 32 CFR 199.10(c) and (d), an initial determination issued by the contractor terminating a provider is appealed directly to a hearing conducted by the TMA Office of Appeals and Hearings.

5.3. Retrospective Determinations Related To DRG Validation

Contractor requirements related to DRG validation are addressed in Chapter 7, Section 1, paragraph 3.6. and paragraphs 4.3. through 4.6. Although there are no reconsideration or appeal rights available for changes resulting from DRG validation, the same process used for making a reconsideration determination is used for rereviews of changes resulting from DRG validation, including allowing the non-network participating provider or beneficiary (if the DRG coding change resulted in noncoverage of a furnished service) the opportunity to provide additional information. The notice of the rereview of changes resulting from DRG validation shall include the information in Chapter 7, Section 1, paragraph 4.4.1. through 4.4.7., and shall also include a statement that the determination is final and that no further appeal rights are available.

5.4. Provider Status

An initial determination denying a provider's request for approval as an authorized TRICARE provider is a factual determination. Under 32 CFR 199.10(c), a reconsideration determination issued by the contractor denying a provider's request for approval as an authorized TRICARE provider is appealable to a formal review conducted by the TMA Office of Appeals and Hearings.

5.5. Hospice Care

An initial determination denying hospice care is a factual determination. Under 32 CFR 199.4(e)(19)(vii), a beneficiary or provider is entitled to appeal rights for cases involving a denial of hospice care benefits in accordance with the provisions of 32 CFR 199.10. An adverse reconsideration determination issued by the contractor denying TRICARE cost-sharing for hospice care is appealed to a formal review conducted by the TMA Office of Appeals and Hearings.

5.6. TRICARE Dental Programs

A beneficiary or participating provider is entitled to appeal rights for cases involving a denial of coverage under the TRICARE Active Duty Family Member Dental Plan, the TRICARE Selected Reserve Dental Program, or the TRICARE Retiree Dental Program. An adverse reconsideration determination issued by the contractor is appealed to a formal review conducted by the TMA Office of Appeals and Hearings.

5.7. Circumvention of the TRICARE DRG System

A hospital dissatisfied with a determination regarding circumvention of the TRICARE DRG system may obtain a reconsideration. Circumvention is defined as an action that results in unnecessary multiple admissions of an individual or other inappropriate medical practices. (Refer to Chapter 7, Section 1, paragraph 4.2.). An adverse reconsideration determination issued by the contractor finding circumvention of the TRICARE DRG system is appealed to a formal review conducted by the TMA Office of Appeals and Hearings.

5.8. Program for Persons with Disabilities (PFPWD)

Initial determinations denying eligibility as a PFPWD beneficiary and denying services and supplies under the PFPWD, are considered factual determinations, in addition, waiver of liability, which is applicable to the basic program (32 CFR 199.4) is not applicable to the PFPWD (32 CFR 199.5). If the reconsideration determination is less than fully favorable, the appealing party shall be advised of the right to file a request for a formal review with the TMA Office of Appeals and Hearings.

5.9. Foreign Claims

Denials of authorizations, services and supplies under the TRICARE Overseas Program, are considered factual determinations. If the reconsideration determination is less than fully favorable, the appealing party shall be advised of the right to file a request for a formal review with the TMA Office of Appeals and Hearings.